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A 006	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: The Governing Body failed to organize themselves in a manner to develop and implement policies and procedure to assure patient's safety. Cross reference; Tag A 0057. §482.13 (c) (2) Governing body failed to develop and implement polices and procedures to assure services were provided in a safe setting. The governing failed to develop and implement policies and procedures related to defining lines of authority and delegation of responsibility during the admission process to assure safety of the patient. The hospital staff failed to implement admission office procedures regarding physician assessment and evaluation for admission. Cross reference: Tag A 0204. §482.23 (b) (3) Nursing staff failed to assess the patient's level of supervision needed to assure patient safety. Nursing staff failed to assure effective communication between the physician and other members of the staff needed to assure patient safety. Cross reference: Tag A 0207. §482.23 (b) (6) Hospital staff failed to implement admission policy	A 006		8/24/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 006	Continued From page 1 and procedure designed to assure patient and staff safety. The hospital staff failed to provide accurate documentation of procedures to assure patient and staff protection.	A 006		
A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: The hospital was identified to have had a practice of allowing law enforcement officers to carry guns and release patients from handcuffs in a lobby area where other patients and visitors may be present. These patients had been assessed as being dangerous to themselves or others and were transported to the hospital for care and treatment. Cross reference; Tag A 0057. §482.13 (c) (2) Governing body failed to develop and implement polices and procedures to assure services were provided in a safe setting. The governing failed to develop and implement policies and procedures related to defining lines of authority and delegation of responsibility during the admission process to assure safety of the patient. The hospital staff failed to implement admission office procedures regarding physician assessment and evaluation for admission.	A 038		8/16/05
A 057	482.13(c)(2) RECEIVE CARE IN A SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by:	A 057		11/1/05

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A 057	Continued From page 2	A 057		

Based on record review and interviews the governing body failed to develop and implement polices and procedures to assure services were provided in a safe setting. The governing failed to develop and implement policies and procedures related to defining lines of authority and delegation of responsibility during the admission process to assure safety of the patient. The hospital staff failed to implement admission office procedures regarding physician assessment and evaluation for admission.

The findings includes:

1. During observation on 7/25/05, between 4pm-4:30pm., red signs were noted on the door to the Admission Office and the door to the lobby of the Unit 2 Residential Building prohibiting guns from being brought into the buildings.

Review of an incident report revealed at approximately 4:15pm on 7/22/05, a county deputy arrived at the Unit 2 Building lobby with patient #1. The deputy released the patient's handcuffs and the patient abruptly grabbed or ripped the deputy's belt with his firearm and fired numerous shots inflicting injury to a staff. The patient then shot himself in the head and expired shortly thereafter.

Review of the North Carolina Administrative Rules, Chapter 28- Mental Health, State Operated Facilities and Services 10A NCAC 28I .0404 Firearms, notes no firearms shall be brought into the buildings of any institution of the Division. Law officers shall either leave firearms in their locked motor vehicle or deposit their firearms with responsible personnel of the institution.

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Review of the hospital's policy on 7/27/05, revealed unauthorized weapons on the hospital campus represent a high risk event for the protection of patients and staff. The policy noted weapons are not to be carried at the hospital except by certified law enforcement personnel or correctional officers from the Department of Correction while in performance of their duties, and/or others specifically so authorized by the Cherry Hospital Chief of Police. The policy revealed weapons are not allowed in any patient residential area or screening/admissions, expect by law enforcement. " In all other situations, staff shall ask officers to remove and store their weapons in a locked area. (Should an officer decline, every effort will be made to keep that officer out of patient residential areas, including transporting patient to officer location out of ward). "

Review of a memorandum dated 7/27/05, noted the Hospital's Executive Committee determined on July 25, 2005 to prohibit firearms in all patient care and residential areas, including Screening/Admission Office and U2 lobby. This prohibition includes firearms in the possession of law enforcement officers.

During interview on 7/27/05, staff stated patients transported by law enforcement to the hospital for admission have been initially seen in their local county and have been assessed as being dangerous to self or others.

During interview staff confirmed that on Friday 7/22/05, patient #1, after being released from handcuffs by a county deputy in the lobby of the Unit 2 Building, took the deputy's firearm from his

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holster and shot several times. Staff stated it was thought the patient had shot several times while removing the gun from holster, shot a staff three times, the wall twice and a sofa several times before shooting and killing himself. Staff stated they were told patient #1 had emptied the gun by shooting all the ammunition from the weapon.

Staff stated procedures were immediately put in place on Friday 7/22/05, after the shooting, to prohibit law enforcement officers from bringing a gun into the Admission Office, Unit 2 building or any other residential building.

The Medical Director stated during the weekend the patients were seen by the on call physician in the Admission Office and hospital staff provided transportation to the unit. The Medical Director stated on Monday 7/25/05, the hospital continued to prohibit the guns in the Admission Office and on the lobby of the Residential Building, Unit 2. The Medical Director stated the hospital went back to allowing the patients to be seen by the physician in either the Admission Office or on the unit during the admission procedure. The hospital went back to having the county deputy transport the patient to the residential building and the releasing of handcuffs in the lobby of the building. The physician stated there is traffic in the lobby of the residential building and confirmed there maybe patients and visitors in the lobby where the patients are released from handcuffs. The Medical Director confirmed the lobby is not cleared of others when initially releasing the handcuffs from a patient being admitted.

During interview on 7/28/05, staff stated when the handcuffs are released some patients will express aggressive behaviors. Staff stated for

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example, on the afternoon of 7/27/05, a patient had been " out of control in the lobby. " Staff confirmed at times discharged patients sit in the lobby waiting for transportation to the bus station and visitors maybe in the waiting area when a new admission is brought to the lobby.

2. Review of the facilities admission policy on 7/28/05, revealed the admission office provides screening, evaluation, admission and referral services for each applicant. Evaluation for appropriateness for hospitalization is carried out by hospital physicians with the assistance of the admission office support staff and in collaboration with the community's referral physicians.

The admission policy further revealed the procedure included a specific intake assessment that ensures sufficient information is ascertained to develop initial treatment orders and contribute to subsequent treatment planning.

Review of the admission office procedures on 7/27/05, revealed the physician will complete an assessment.

Review of incident and accident report, dated 7/22/05, revealed at approximately 4:15 pm a county deputy arrived to U2 Bldg lobby with client # 1. The deputy released patient #1's handcuffs and he abruptly grabbed or ripped the deputy's belt with firearm and fired numerous shots inflicting injury to one staff. Then shot himself in the head and expired shortly thereafter.

Review of Notice of Need for Transportation Order on 7/25/05, revealed on the date and time shown on the document, patient #1 was immediately brought to the specified facility and

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A 057	Continued From page 6 turned over to the custody of the facility. The document revealed the receiving 24 hour facility to be the Hospital. The document revealed patient #1 was turned over to the 24 hour facility on 7/22/05 at 4 p.m.. This document was signed by the county deputy. Review of the Custody Order for Involuntary Commitment revealed the deputy took custody of patient #1, transported and placed him in the temporary custody of the facility for observation and treatment. The document revealed the deputy signed and dated patient #1 was delivered to the facility on 7/22/05 at 4 p.m.. Review of an admission document on 7/25/05, revealed patient #1's vital signs were taken in the Admission Office on 7/22/05 at 3:50 p.m.. During interview on 7/27/05, facility staff stated, patients are brought first to the admission office. At that time, the commitment papers are taken from the deputy and a chart is initiated. The patient is then asked to sign documents that include the Privacy Policy, Authorization for Contact and insurance forms for reimbursement. The staff stated, patient information is entered into the computer for admission in the Admission Office. The patient's picture is taken and a wrist band is applied. Staff stated, originally it was procedure for the physician to evaluate the patient in the Admission Office, however, through the years that had changed. Staff stated, between 8 a.m. and 3 p.m. the patient is seen by the physician on the Unit that the patient will reside, at which time admission orders are written on the Unit. Staff stated, during the afternoon, evening and night hours, the physician sees the patient in the Admission Office, at which time admission	A 057		

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A 057	Continued From page 7 orders are written. The staff further stated, the patient is delivered to the Admission Office by the deputy to process the paperwork and is turned back over to the deputy for transportation to the residential building. Staff stated, there are two counties, one in-particular, which some of the deputies, after delivering the patient to the Admission Office, will not transport them to the residential building. If the deputy will not take them to the residential building, hospital security or transportation staff will provide the transportation. Further, there have been instances when the patient was not seen by the physician in the Admission Office and when seen on the residential unit was found not to meet criteria for admission. Because the deputy has left, the patient would reside on the residential unit waiting for transportation home. During interview on 7/27/05, another staff stated, one County District Attorney has instructed the deputies not to transport the patient any further than the Admission Office. During interviews staff stated, when the patient is transported by the deputy to the residential unit the residential staff meets the deputy in the building's front lobby. At that point the patient is released from handcuffs and the deputy leaves. During interview on 7/29/05, staff stated, there was a question whether patient #1 was considered admitted at the time he shot himself in the residential unit's lobby. Staff stated " That is a legal issue." During interview, the Medical Director stated on 7/29/05, admitting a patient is a process. He	A 057		

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A 057	Continued From page 8	A 057		

stated, the process is not completed until the physician sees the patient and writes admitting orders. The Medical Director stated, it is not good to give admitting orders before being seen by the physician. Therefore, the physician stated, patient #1 was really not admitted as this patient #1 was in the process.

The Medical Director confirmed the patient is brought to the residential unit by the deputy and is released in the lobby to the residential unit staff,at that time the deputy leaves. The Medical Director stated, there has been times after the deputy has left, the patient is assessed by the physician and found not to meet criteria for admission. He stated, they are admitted and quickly discharged the next day when transportation can be arranged for their return home.

During interview, facility staff confirmed, there is no policy or procedure that addresses at what point during the admission process, the individual becomes a patient or who has the responsibility for the individual during the admission process to assure his safety.

[Memorandum dated 7/27/05 noted that the Hospital's Executive Committee determined on 7/25/05 to prohibit firearms in all patient care and residential areas, including Screening/Admissions and U2 lobby. The Executive Committee met on 7/26/05 and discussed having Medical Staff develop and implement a plan requiring all physicians to complete the patient's intake assessments in the Admission Office prior to transporting the patient to the residential units. A memorandum dated 7/29/05 noted, effective 4 p.m. 7/29/05, all admission psychiatric assessments will be conducted in the Admission

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A 057	Continued From page 9 Office. The memorandum noted newly admitted patients brought to building by law enforcement officers shall take place in a designated room. Change of custody shall occur in this room for privacy and safety of patients and staff.]	A 057		
A 199	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Nursing Services failed to have an effective system to identify when safety procedures are not implemented. Cross reference: Tag A 0204. §482.23 (b) (3) Nursing staff failed to assess the patient's level of supervision needed to assure patient safety. Nursing staff failed to assure effective communication between the physician and other members of the staff needed to assure patient safety. Cross reference: Tag A 0207. §482.23 (b) (6) Hospital staff failed to implement admission policy and procedure designed to assure patient and staff safety. The hospital staff failed to provide accurate documentation of procedures to assure patient and staff protection.	A 199		8/24/05
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.	A 204		8/24/05

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A 204	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review and interviews, nursing staff failed to assess the patient's level of supervision needed to assure safety. Nursing staff failed to assure effective communication between the physician and other members of the staff needed to assure patient safety. This affected one of one audit patient (#11) that was to be on ward restriction. The findings includes: Review of an investigation report dated 2/21/05, revealed patient #11 had been very delusional since admission. The investigation report noted on 2/17/05 patient #11 attempted to escape from the Unit 2-3east. The patient was given Benadryl 50mg. at 11:30am. The report revealed the nurse informed the physician of the escape attempt and an order was given for Benadryl 50 mg. and ward restriction/escape precautions. Further review of the investigation report revealed some of the Health Care Technicians working that evening were not aware patient #11 was placed on ward restriction. At 1 p.m. another order was written for Benadryl 25 mg. po, tid and Ativan 2 mg. po, tid for 3 days. The report revealed on the afternoon of 2/17/05, the patient stacked two bedside tables and climbed into the ceiling, placed the tile back and crawled five feet. He then fell through the ceiling into the next room. Another patient, entering his room, found patient #11 lying on the floor. The investigation report noted, the patient stated " I was trying to escape. " Review of patient #11's record on 7/29/05, revealed no documentation from Nursing or Health Care Technicians on 2/17/05 regarding the	A 204		

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attempt to escape at 10 a.m.. There was no documentation of communication with the physician or an order for ward restriction/escape precautions or an assessment to evaluate level of supervision needed to ensure patient's safety. A physician note dated 2/17/05, written at 1 p.m., noted patient was agitated and agitating others and had tried to escape today. There was no other documentation until 4:40 p.m. when the physician wrote a note stating the patient would be placed on constant observation after the patient fell from the ceiling. The note stated the patient had attempted to escape this morning and " ? was trying to escape again. " Review of the patient's record revealed the patient sustained a fractured femur and was transferred to the local hospital.

Upon request for the escape precautions policy and procedure, the only policy provided was related to events following an escape, i.e. grounds search, bloodhound utilization. Review of Policy and Procedure, Suspected Risk, Suicide, revealed the hospital shall take every precautionary measure to reduce the risk of suicide or the potential for self-destructive behavior. The precautions include 30 minute checks, constant awareness (visual observation at all time during the waking hours) and constant observation (require the patient to be within arms length of a staff member).

During interview on 7/29/05, the Medical Director stated there are several levels of precautions. He stated there was close observation which required the patient to be within arms length at all times, constant awareness which would require the patient to be within eyesight of staff at all times, q30 minute checks and q15 minute

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A 204	Continued From page 12 checks. The Medical Director stated there was also elopement precautions/ward restriction for the patient attempting to elope. The Medical Director stated that patient is restricted to the unit and the unit and building is locked and no level of observation is necessarily ordered. During interview on 7/29/05, staff confirmed there was no policy available that addressed procedures related to escape precautions/ward restrictions. During interview, nursing staff stated, generally, if a patient is on escape precautions/ward restrictions they are usually on a level of observation such as q15 minute checks. However, patient #11 had no written or verbal order for a higher level of observation. Review of the Advocate Department summary related to incident revealed neglect was not substantiated. There was not an order written for ward restriction/escape precautions for the incident that occurred earlier in the day. The summary noted that there were some obvious communication problems with the order. However, even if the order had been in place, it would not have prevented the patient ' s escape attempt. He would have still have been allowed in his room without direct supervision with this restriction.	A 204		
A 207	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services.	A 207		8/24/05

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This STANDARD is not met as evidenced by:
Based on observation, record review and interviews, the hospital staff failed to implement admission policy and procedure designed to assure patient and staff safety. The hospital staff failed to provide accurate documentation of procedures to assure patient and staff protection on four of four admission units (2 east, 3 east, 2 west and 3 west) in the Unit 2 Building.

The findings includes:

Review of policy and procedure, Nursing Admissions Workup on 7/27/05, revealed upon entry to U-2 Building, a metal detector will be used to determine presence of any dangerous article such as a weapon. The use of the metal detector will be documented on the patient Search Progress Note.

Observation of room 124 in the U-2 Building on 7/29/05, at 11 a.m. revealed the metal detector was not available to nursing staff during the admission process.

Review of current patient records on 7/29/05, revealed staff had documented using the metal detector by making a check mark on the Search Progress Notes on six of ten admissions records (#5, #6, #7, #8, #9 and #10) during the month of June and July 2005 on unit 2 East. Four of the charts reviewed revealed the patients were admitted in July and two of the charts revealed the patients were admitted in June 2005. The Search Progress Note had been signed by the staff member conducting the search and by the

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	344003	A. BUILDING _____ B. WING _____	C 07/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 207	Continued From page 14 Registered Nurse. The four remaining Search Progress Notes on unit 2 East indicated that the metal detector had not been used by noting NA or leaving the space blank. The other three units sampled on 7/29/05, revealed either the metal detector had been used during the past two months or had not been used at all. For example, on unit 2 West, patient #2 Search Progress Note had been checked that the metal detector had been used. The Search Progress Note had been signed by the staff member conducting the search and by the Registered Nurse. On unit 3 East, patient #3 and #4 Search Progress Notes had been checked that the metal detector had been used. The Search Progress Note had been signed by the staff member conducting the search and by the Registered Nurse. On unit 3 West, a record revealed the metal detector had not been used. During interview on 7/29/05, a Health Care Technician stated the metal detector that is to be used upon admission had been missing for a couple of months. Further interview with nursing staff on 7/29/05, revealed nursing management had only known about the metal detector ' s disappearance recently.	A 207		